MINUTES

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

September 25, 2008
Room 643, Legislative Office Building

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services (LOC) met on Thursday, September 25, 2008 in Room 643 of the Legislative Office Building. Members present were Senator Martin Nesbitt, Co-Chair; Representative Verla Insko, Co-Chair; Senators Austin Allran, Bob Atwater, Vernon Malone, and William Purcell and Representatives Jeff Barnhart, Beverly Earle, Bob England, Jean Farmer-Butterfield, and Fred Steen. Advisory members Senator Larry Shaw, Representatives Van Braxton and William Brisson were also present.

Denise Harb, Shawn Parker, Ben Popkin, Susan Barham, and Rennie Hobby provided staff support to the meeting. Attached is the Visitor Registration Sheet that is made a part of the minutes. (See Attachment No. 1)

Representative Verla Insko, Co-Chair, called the meeting to order and welcomed members and guests. She asked for a motion to approve the minutes from the August 26, 2008 meeting. The motion was made and the minutes were approved.

Representative Insko asked Daniel Hahn, Executive Director of the Alamance, Caswell, Rockingham LME, to come forward and address the committee. Mr. Hahn told members that he would identify, on the local level, the challenges facing the MHDDSA system. (See Attachment No. 2) He explained that as the system has faced difficult challenges, directives to LMEs have changed regularly. He said there was also the challenge of identifying concerns in the community and working with the State to address those items. Mr. Hahn noted that there is concern regarding the limited resources, and where to best place those dollars. Representative Insko stated that returning the Utilization Review function to the LMEs would allow Medicaid, State, and local dollars to commingle. Mr. Hahn also stated that major successes included the communication and cooperation between public agencies, support groups and advocacy groups, and that a 6 year federal SAMHSA grant for $9 million would look at issues that children 0-5 would face in terms of mental health and developmental disabilities issues. Mr. Hahn explained the benefits of tele-psychiatry and he explained the development of a Housing Continuum Referral Model which assists providers in assessing the needs of consumers.

Representative Insko recognized John Corne the new chairman for the Commission on Mental Health, Developmental Disabilities and Substance Abuse Services, and Pat Porter, Ph.D., a consultant working with LOC staff on Developmental Disabilities issues.

Next, David Swann, representing Crossroads Behavioral Healthcare LME (Iredell, Surry, and Yadkin counties), gave an overview of mental health services in rural North

Carolina. Some of the challenges mentioned by Mr. Swann were the recruitment and retention of professional staff; fewer providers due to a lack of volume; the additional costs of providing services to rural areas; and limited public transportation. Mr. Swann reviewed how the facility-based crisis center and the mobile crisis team reduced the State hospital usage and kept people closer to home. He said conclusions drawn showed the need for involuntary capabilities local in the community. Involuntary capabilities reduced the reliance on State hospital services. Referring to service gaps, Mr. Swann emphasized the importance of the need for additional short-term transitional housing in order to step-down people from hospitals, and acute care facilities in the 3 to 6 to 9 month range. Flo Stein from MHDDSAS, added that the Department had been working on a housing plan for 2 years and that the report would be ready shortly to present to the General Assembly.

Dr. Jim Osberg, Chief of State Operated Services, DMHDDSAS, gave an update on the State psychiatric hospitals. Dr. Osberg said that Broughton Hospital had been recertified by CMS and is now receiving Medicare and Medicaid reimbursement. He said that Mr. Tom Mahle began the position as Broughton director in August. He also said that the Joint Commission found that Broughton hospital was out of compliance with 29 Joint Commission standards. In order to retain accreditation there can only be a maximum of 16 standards out of compliance. Broughton appealed that finding and reduced to 18 the number of standards with which is it out of compliance. Dr. Osberg said a second letter of appeal would be mailed shortly and a response was expected from CMS in October. He said that through funds established in the expansion budget, compliance positions for State Operated Services would be filled so that mock surveys could be conducted to help improve the compliance record.

It was suggested that staff review and report at the next LOC meeting on issues that have occurred in the last one or two years regarding noncompliance that would pinpoint problem issues. Dr. Osberg responded that Secretary Benton developed a Management and Operations workgroup which reported on problem areas of the hospitals, including inadequate hospital staffing , salaries for direct care staff, and the number of patients that are admitted or referred to the hospitals. He said that decreasing the demand on State hospitals was part of the solution, and there needed to be a change in the culture – staff needs to care about patients.

Dr. Osberg said that an outside consulting group, the Compass Group, was brought in to identify problem areas at Cherry Hospital that led to the hospital's decertification and poor performance. The report would be submitted to the Secretary later today. Senator Nesbitt added that part of the problem was that the hospitals were not located in urban areas making it difficult to recruit and retain staff. He said decreasing the population in the hospitals would help put the staff to patient ratio better in balance. Members expressed outrage over a recent incident of neglect at Cherry in which a patient died, and said that all employees involved should have lost their jobs. Dr. Osberg responded that the ward where the incident happened had been closed, and staff not involved had been disbursed to other wards. He said the goal was to have 2 nurses on each ward per shift.

Continuing, Dr. Osberg said the plan for the final merger of Dix Hospital and Central Regional was on hold pending the outcome of the lawsuit brought by Disability Rights of North Carolina. He said that once the transfer was final there would be 60 beds at Dix that would continue on an interim basis in accordance with an agreement with Wake County. He also said that the Forensic Minimum Security Program would remain on an interim basis at Dix. The Adolescent Admission beds and the Adolescent Residential beds would remain at Dix while renovations are taking place at Umstead Hospital. Once the renovation is complete in December the children currently at Umstead and the children from Dix will be combined in the renovated spaces. He said that the Department was paying for diversions into other hospitals that the Department has contracts with to try to help communities with the shortage of beds at Cherry. Senator Nesbitt added that the private beds that the State is purchasing with funds appropriated in the 2008 expansion budget would also offer more beds.

After lunch, Dr. William Lawrence, Acting Director of the Division of Medical Assistance (DMA), gave an update on the suspension of Medicaid benefits and Medicaid enrollment for recipients in institutions for mental disease or those incarcerated. (See Attachment No. 4) Dr. Lawrence said effective September 1, 2008, a person entering an institution or incarcerated receiving Medicaid, would now have their status suspended rather than terminated through their next certification date.

Dr. Lawrence also reviewed a chart on community support expenditures. (See Attachment No. 4) He said that DMA was currently waiting on approval from the Centers for Medicaid and Medicare Services (CMS) on the State Plan Amendment which updates changes made in legislation and allows tier rates for community support, and requires that every community support provider organization to employ a licensed clinician. He said that several items in legislation had already been implemented. Dr. Lawrence also said that CMS had visited Value Options and EDS, the claims processor, and visited several LMEs. He said that CMS would provide feedback regarding those visits.

Regarding provider appeals related to community support and recipient appeals, Dr. Lawrence said that the appeals were down below 1,000 recipient appeals compared to over 7,000 at one point. He said that these appeals include both appeals at the Office of Administrative Hearings and within DHHS that were filed prior to the passage of S.L. 2008-107. Starting in October 2008, all recipient appeals will go directly to OAH and provider cases in OAH before have had their jurisdiction switched, and go back to the Department appeals process for completion. Tara Larson from DMA pointed out that 70% to 80% of the 6,000 recipient cases could still appeal to OAH. Ms. Larson was asked the status of the community support providers who appealed cases. Ms. Larson said she would get the information, and mentioned that a change in legislation for community support stated that if a provider is under appeal there is also a process for suspending payment pending the appeal.

Representative Insko then asked Dr. Lawrence to comment on trends in Community Support spending. She noted, from Attachment 4 that costs for both FY 2007 and FY 2008 were over $800 million, much higher than the $200 million that the service was

expected to cost. Representative Insko also asked whether the use has grown of enhanced mental health services other than Community Support, and whether people who need services are getting them. Dr. Lawrence agreed that costs are beginning to decline and responded that the cost of the first quarter FY 2008 costs over $110 million less than in the first quarter of FY 2007. Dr. Lawrence also noted that the number of people served in FY 2008 is similar to FY 2007, but that the number being served in Community Support specifically had probably declined. Dr. Lawrence also noted that DMA collects data about the use of both Community Support and Enhanced Services, in order to determine outcomes.

Senator Nesbitt then reviewed the MH/DD/SA System Indicators chart. (See Attachment No. 5) He noted that graphs #3 and #4 showed the significance of placing people in local beds in order to reduce the hospital 1-7 day admissions and reduce capacity in the hospitals.

Next, Leza Wainwright, Co-Director for the Division of MH/DD/SAS, discussed Traumatic Brain Injury (TBI) Services. (See Attachment No. 6) Ms. Wainwright began by explaining the difference between the two types of acquired brain injury – traumatic brain injury and non-traumatic brain injury. She reviewed prevalent statistics regarding TBI including recognizing the fact that there is a growing incidence of TBI sustained by the military, particularly those injured in Iraq and Afghanistan. Ms. Wainwright also reviewed the types of services available in North Carolina under Medicaid and State funded services. TBI funds are not distributed on a fee-for-service basis, making it more difficult to determine how many people are served. However, she noted that according to diagnosis code, there are 302 people served with State funds and 13 served in State facilities. She then reviewed the benefits and considerations for pursing a Medicaid Waiver for TBI services and explained the role of North Carolina's TBI Council. Members noted that if a person received a TBI after the age of 22 and did not qualify for services, there was no help available. Representative Insko suggested that the committee hear from someone with a medical background on those in the military who have received a traumatic brain injury, and how a TBI Waiver might benefit veterans. Representative Insko announced that there was a website on adults with traumatic brain injury from falls at www.publichealthgrandround.unc.edu.

Next, Flo Stein, Chief of Community Policy Management of the Division of MHDDSAS, gave an overview of the funding provided to expand the regional substance abuse initiative – Cross-Area Service Programs (CASP). (See Attachment No. 7) Ms. Stein reviewed the legislation establishing the funding and explained the 4 different initiatives. She said that 2 new programs had been added with funding provided during the last legislative session – Southeastern Recovery Alternatives and Tri County Community Health. Ms. Stein also said that the Department was working with the Department of Juvenile Justice and Delinquency Prevention to coordinate services for children with substance abuse and mental health issues. Currently, negotiations are underway with 2 LMEs to set up a coordinated screening, evaluation, placement, and treatment system of care. She noted that the Department and the Institute of Medicine had worked together on the Substance Abuse Taskforce, which was funded by the General Assembly, to establish

a better plan for substance abuse in North Carolina; the final report of the Taskforce will be available later this interim. Ms. Stein reviewed the model program, and said there was a movement to change the focus of the programs from individual services to requiring the programs to help people gain recovery.

Next, Trish Hussey, Executive Director of Freedom House Recovery Center, described the Center, the 5 district outpatient clinic sites in Orange, Person and Chatham counties, and the long term residential homes in operation in Durham County. (See Attachment No. 8) Ms. Hussey reviewed the array of substance abuse services offered, and explained how CASP funding had benefited the people with substance abuse issues through housing and services. She said that Freedom House and Oxford House had partnered to provide supportive housing in rural areas, and were opening additional Oxford Houses in Person and Chatham counties. Ms. Hussey said that once people were out of service, outcomes were tracked for 6 to 12 months. She said the success rate ran from 64% - 70% for those who remained clean and sober, who found jobs, maintained those jobs, and who found housing. Ms. Hussey added that there was a strong support system in the community.

Senator Nesbitt then called on members of the audience, who had signed up previously, to come forward for the public comment period of the agenda. Concerns addressed by the audience included:

- Continued support of CASP program which is making a difference in the long term recovery of individuals.
- Look at tiered waivers in-depth to see negative impact. (Senator Nesbitt asked that this issue be examined.)
- Standup for Recovery Campaign – a means for community to share voices, stories and provide an advocacy platform for services. www.Recoverync.org.
- The need for one consistent definition across all agencies for "a paid family caregiver for Medicaid and State dollars." Under comprehensive tiered waiver, one must choose between providing all services oneself or have outside staff provide all services. Sharing services not an option. (Leza Wainwright was asked to look into a mix and match combination home support services waiver and report back at the next LOC meeting.)
- Need for 1,000 beds at Dix hospital.
- Pay providers proportionally for services provided based on skills and time. (Senator Nesbitt responded that tiered rates for Community Support, as required by S.L. 2008-107, would take care of this problem.)
- Use in-house inspectors, the same ones that CMS uses, to stay on top of conditions at the hospitals.
- Hire people with morals to work at Cherry hospital instead of retraining staff currently at Cherry.
- Family Care Homes need help with more one-on-one care. Personal assistant could be used as a model if more highly trained and skilled as a nursing assistant.
- Concern for law enforcement personnel being overtaxed with the mentally ill. Hospital must take custody of patient upon arrival. (Senator Nesbitt said that $8 million was appropriated to secure local beds to help cut time spent on transporting patients to State facilities and should help law enforcement officers.)

- Must move forward and move patients to Central Regional Hospital. Dix is not safer than Central Regional.
- Low staff morale at hospitals due to lack of involvement in decisions being made, not allowed to negotiate working conditions. Support Mental Health Workers' bill of rights.
- Staff, families of consumers, and consumer all fear retaliation if they complain of conditions at the hospitals.
- Do not rush to move patients from Dix. Make sure all issues of concern are addressed.

There being no further business, the meeting adjourned at 3:40 PM.

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Senator Martin Nesbitt, Co-Chair	Representative Verla Insko, Co-Chair

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Rennie Hobby, Committee Assistant